A BRIEF HISTORY
OF THE

LOUISIANA PATIENT'S COMPENSATION FUND

In the early 1970's, a problem of crisis proportions arose in medical malpractice liability in the U.S. Because of an explosion in both loss frequency and severity, insurance carriers found themselves forced to raise malpractice premiums by massive percentages. Ultimately, a number of carriers retired from writing malpractice liability altogether. The effect on physicians and hospitals was chilling. Some found themselves unable to pay indicated premiums and some found themselves unable to obtain coverage at any price. Certain areas of the country were harder hit than others and, in those areas, physicians started leaving their practices or practicing without coverage. Louisiana was one of the states facing this situation.

It was in this climate that the 1975 legislative session opened and **Act 817** was passed which created the Louisiana Patient's Compensation Fund to cover the private health care providers. The purpose of this legislation was twofold. First, it was to ensure that a stable and affordable market existed for malpractice insurance and thereby keeping practitioners in the state. Second, it was to create a viable fund for compensating claimants. It also provided a statutory cap on total liability. The $500,000 cap was considered an equitable tradeoff between compensating the most injured claimants adequately and maintaining the financial stability of the Patient's Compensation Fund. Private health care providers who choose to enroll in the PCF remain responsible for the first $100,000 of each claim, and are required to provide the Patient's Compensation Fund with evidence of insurance coverage. R.S. 40:1299.41 *et seq* detailed the specifics of the operation of the Patient's Compensation Fund, and also provided for the Medical Review Panel process, in which each claim is reviewed by three licensed Louisiana health care providers, one (1) appointed by the plaintiff, one (1) by the defendant and the third by mutual agreement of the first two appointees. The attorney chairman is selected by mutual agreement of the plaintiff and defendant. After reviewing the case and rendering an opinion, the health care providers that were members of the panel may be deposed by both the plaintiff and defendant. The medical review panel process is the first step in pursuing a claim against a health care provider.

The requirement for an underlying proof of insurance allows the private providers to supply the Patient's Compensation Fund with an acceptable security valued at $125,000 and self-insure their first $100,000 exposure in lieu of an actual insurance policy for the primary layer of $100,000. Roughly 20% of all active enrollees are currently self-insured. In 1984, the statute was amended to allow for the payment of <u>all</u> related medical expenses. This change allowed those patients with more severe injuries to have medical expenses paid on an ongoing basis. This was an important concession as these expenses have no statutory limit on the total payment. These expenses are paid in addition to the general damages settlement or judgment payment. This provision also reduces the payments that were being made or could have been made by Medicare and Medicaid. This lessens the burden to these programs.

In the 1990 legislative session, a major change was made in the format and operation of the Patient's Compensation Fund. As a result of an increasing concern by the private health care providers for the financial integrity of the Patient's Compensation Fund, the statute was revised to move the operation of the Patient's Compensation Fund from the Department of Insurance and the Attorney General's office to an Oversight Board. This was intended to give the Patient's Compensation Fund more autonomy of operation and also to allow for the creation of a trained staff to reduce the time and expense associated with claims processing. This change was felt necessary in protecting the ongoing financial stability of the Patient's Compensation Fund. This in turn ensures availability of coverage to the private health care providers and compensation to those injured as a result of medical malpractice.

The creation of the Oversight Board gave providers greater input, and also greater responsibility, in the operation of the Patient's Compensation Fund. The Oversight Board is drawn from the provider groups based on their proportional representation in the Patient's Compensation Fund as a whole. The members of the Oversight Board are appointed by the Governor from nominations by the various medical professional associations. In addition to physician and hospital members, the Oversight Board includes a representative from the miscellaneous classes, and also an insurance industry executive (from a carrier not writing malpractice insurance).

Today, the Patient's Compensation Fund insures over 17,000 private health care providers in Louisiana, including physicians, hospitals, clinics, dentists, ambulance services, optometrists, nurses, chiropractors, nursing homes, physical therapists, and a wide variety of others. Funds paid in by the members are approximately $170 million annually, and claim payments of at least $115 million have been made for the last three fiscal years, with the same amount expected in the current fiscal year. While the legality of the $500,000 cap has come into question a number of times, the Louisiana Supreme Court has, thus far, ruled it to be constitutional. Litigation challenging the constitutionality of the cap is currently pending. Further, bills to increase the cap have been filed each session for the last several years and this activity is expected to continue. While no bill has completed the process and been enacted, the possibility still exists that there could be changes in the cap and the system as a whole.

The purpose for creating the Patient's Compensation Fund was to offer a stable, affordable market for medical malpractice liability insurance and also make available a reliable and secure source of compensation for injured patients and their families. The providers have willingly accepted large premium increases over the past years to ensure the fiscal integrity of the Patient's Compensation Fund to financially meet its obligations.